Central Coast Endocrinology

116 Palisade Dr. Suite 301
Santa Maria, CA, 93454
Phone: (805) 349-8972
Fax: (805) 346-2644

Dear Patient:

The enclosed paperwork needs to be completed prior to your appointment. Please take the time to fill out this paperwork completely to help the doctor evaluate your medical condition thoroughly and bring it in at the time of your appointment.

If you arrived to your appointment without having filled out the necessary paperwork, you may be rescheduled for a later date. If you misplace or lose the paperwork please call our office so that we may send you a new packet or come in at least 30 minutes before your appointment time to fill out the paperwork.

Also, please bring with you a list of your medications, including the strength and how many times a day you take it. Please bring in your I.D, insurance card and drug benefit card if you have one. ***If you have a glucose meter, please bring it with you at every appointment.***

If you have an authorization or referral please bring it in at the time of your appointment. Please notify the office of any change in your doctor if one has occurred between the scheduling of your appointment and appointment time. ***Please note that if your insurance requires prior authorization for this appointment or any subsequent appointments, it is the patient's responsibility to obtain the authorization. If no authorization is obtained and your insurance does not cover your appointment charges, you will be financially responsible for any unpaid charges.***

Thank you for your cooperation, we look forward to meeting your medical needs.

____
Has an appointment on

____
With (Provider)

Date: ____________________ at ____________________ am/pm

☐ Main Office: 116 Palisade Dr. Suite 301, Santa Maria, CA 93454

☐ Pismo Beach Office: 911 Oak Park Blvd, Suite 105, Pismo Beach, CA 93449

☐ San Luis Obispo Office: 1250 Peach St. Suite H, San Luis Obispo, CA 93401

Direction to Dr. Lai's Office
Locations in Santa Maria and Pismo Beach

Main Office:

Marian Hancock Medical Building: 116 Palisade Dr. Suite 301, Santa Maria, CA 93454

Traveling North on 101 Freeway

- Travel N to the Main St exit
- Turn left at the first stop sign; Nicholson Ave
- Turn right at signal light (Shell Station), you will be traveling E on Main St
- Turn right onto Palisade Dr.
- The office is located on the left hand side in the three story Marian Hancock Building on the third floor.

Traveling South on 101 Freeway

- Travel S to the Main St exit
- Turn left at signal, you will be traveling E on Main St
- Drive under the 101 freeway overpass
- Turn right onto Palisade Dr.
- The office is located on the left hand side in the three story Marian Hancock Building on the third floor.

Pismo Beach Office:

Pismo Beach Medical Center: 911 Oak Park Blvd, Suite 105, Pismo Beach, CA

Traveling North on 101 Freeway

- Travel N to the Oak Park Blvd Exit
- Turn left onto E. Branch heading towards Oak Park Blvd
- Make a right turn onto Oak Park Blvd
- Make a left turn on James Way
- Turn into the first driveway on right
- The office is in the middle of the complex, Suite 105

Traveling South on 101 Freeway

- Travel S to the Oak Park Blvd Exit
- Cross over the 101 heading E on Oak Park Blvd
- Make a left hand turn on James Way
- Turn into first driveway on right
- The office is in the middle of the complex, Suite 105

San Luis Obispo Office

Fremont Medical Plaza: 1250 Peach St. Suite H, San Luis Obispo, Ca 93401

Traveling North on 101 Freeway

- Exit on Toro St.(toward Morro Bay/Hearst Castle)
- Turn left on Santa Rosa St.
- Turn left on Peach St.

Traveling South on 101 Freeway

- Exit Santa Rosa St.
- Merge onto Olive St.
- Turn right on Santa Rosa St.
- Take 2nd left onto Peach St.

CENTRAL COAST ENDOCRINOLOGY

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Primary Phone: ( )	Home phone no.: ( )	SSI#

Mailing Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Central Coast Endocrinology or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Central Coast Endocrinology
805-349-8972

Patient Name: ______________________________

Office Policies

The following is a statement of office policies that we request you ***read, initial and sign*** prior to any treatment

___ Payment of Account: If you do not have insurance or if we are not contracted with your insurance, then full payment is required at time of service. As a professional courtesy, we will submit claims to your insurance company(ies) however; **we do require your co-payment at time of service.** Your insurance contract is between you and your insurance company. If your insurance company has not paid your claim in full within **60** days the balance on your account will be your responsibility.

___ **Compliance:** The doctor and the staff will be providing you with top-quality professional care and it is your responsibility to follow the doctor's directions regarding your medical treatment. If you are unable or unwilling to do so, it may become necessary to have you establish with another physician.

___ Courtesy to Dr. Michael Lai's staff: Our staff has your best care and concern at heart. Please be courteous to our health care staff.

___ Lab and Test Results: Our office usually receives the results within one week after tests are completed. If the tests are **abnormal** we will contact you to schedule an appointment to discuss results. **To eliminate the overload of office calls, we ask that you do not call the office any earlier than 3 days after you have the tests done, unless advised by office staff.**

___ **Missed Appointments:** We require at least 24 (business) hour cancellation notice. **The reminder call our office makes is a "courtesy" call. It is your responsibility to know your appointment time.** Missed appointments add to the overall cost of care, as our trained personnel and medical services are not being utilized. The no-show/fail to cancel fee is **$100.00**. New patient no show/fail to cancel fee is **$150.00**. Please help us better serve you by keeping your appointments. **If you have a glucose meter bring it to each appointment. If you come to an appointment without your meter, you will be rescheduled and assessed the no show fee.**

___ Prescription refills: If you need a prescription refilled, **please call your pharmacy.** If you have no remaining refills, the pharmacy will contact our office.

___ Lab slips: A lab slip will be given to you during your appointment if needed. If you lose the slip and an office staff member replaces it or send it to a laboratory for you, there will be a **$10.00 charge.**

___ Prior Authorizations: If your insurance carrier requires our staff to contact them for a prior authorization for medications OR procedures, you will be charged **$40.00 per authorization.**

Fees not covered by insurance, out of pocket costs to patient

Medical Records Transfers	**$25.00**
Forms to be Signed	**$25.00**
Forms to be Filled Out	**$50.00 minimum**
Letters Written	**$50.00 minimum**
E-Mail and Phone Consultations	**$50.00 minimum**
Annual exams, work or DMV	
Physicals if not covered by insurance	**$200.00**
Medical-Legal Consultation	**$250.00-$500.00hr**

Thank you for understanding our Office and Financial Policies. Please let us know if you have any questions.

I have read the above policies, I understand and agree to the policies of the office of Central Coast Endocrinology

Signature of Patient/Responsible party: _________________________ Date: _______________

Authorization to Release Medical Information

I,______________________________ hereby authorize Dr. Michael K. Lai, Dr. Thomas Knecht, Cindy Buchanan, PA-C, Molly Wagman, RD, CDE to release my medical records to my primary care provider, any medical professional that I am being referred to or my insurance carrier.

I wish for the following individuals or organizations to also have access to my medical records:

____________________________________ date_________________________

____________________________________ date_________________________

____________________________________ date_________________________

____________________________________ ____________________________

Signature witness

____

Relationship

<u>Informed Consent</u>

Standard of Practice and Code of Ethics

I have the following rights:

- The right to information/disclosure regarding costs and benefits of treatment
- The right to ask questions related to treatment recommendations
- Once educated on my condition; I have the right and responsibility to make the ultimate decisions about how I will incorporate recommended treatment and any lifestyle recommendations into my life.

I consent to treatment by Michael K Lai, MD /Dr. Thomas Knecht/ and /or Cindy Buchanan PA-C

Patient/ Guardian: Signature_________________________________ Date:_______________

Insurance Co-Payments/Co-insurance & Patient Financial Responsibility

It is the patient's responsibility to:

To know his or her insurance policy. Patients should be aware of the benefit coverage, whether a healthcare provider is contracted with their plan, covered and non-covered benefits, authorization requirements, and out of pocket costs such as; deductibles, coinsurance and co-payments. *Please contact your insurance carrier directly if you have questions regarding coverage and payment.*

To obtain a referral from his/her Primary Care Physician (PCP) and/or authorization for treatment from their insurance carrier prior to receiving services. Assistance is available for patients who need require additional help. ***Any non-covered services are the financial responsibility of the patient.***

- To pay his/her co-pay at time of service
- To pay any deductible and co-insurance amounts not covered by their insurance
- To promptly pay any patient responsibility indicated by his/her insurance carrier
- To pay all no show fees prior to any upcoming appointments, this applies to appointments that are missed without cancelling or cancelled in less than 24 hours

If you miss 3 appointments (either no show or cancel), we will notify your primary care provider and we will require a new referral in order to continue your treatment.

We thank you for choosing our practice. We look forward to working with you to help reach your goals.

I have read and understand this policy:

Patient/Guardian: Signature___________________________________ Date:_____________

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the rights to request a restriction on uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

<u>I wish to be contacted in the following manner (check all that apply):</u>

- Home telephone: ____
  __ Leave message with detailed information
  __ Leave message with call back number only

- Written Communication
  __ Mail to my home address
  __ Mail to my work or office address
  __ Fax to the following number: _____________________

- Work Telephone:____
  __ Leave message with detailed information
  __ Leave message with call back number

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to any authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. The information provided above will constitute an adequate record.

______________________________	___________________________	__________
Patient's Signature	Print Name	Date

Note: Uses and disclosures for information may be permitted without prior consent in an emergency

Michael K Lai, MD
Thomas Knecht, MD
Cindy Buchanan, PAC
Jessica Joslyn, PAC
Molly Wagman, RD, CDE
116 Palisade Dr. Suite 301
Santa Maria, CA. 93454
Phone: (805)349-8972 fax: (805)346-2644

HEALTH QUESTIONAIRE

Date: ___________________

Name: __________________________________ Nick Name: _____________ Age: _____ DOB: _________

Occupation: ______________________________ Current: ____________ Retired: ____________________

Number of hours you work per day: _________ Days of the week you work: ________________________

Describe your job and activity level: ____

Who do you live with: ____

1. Reason for visit:____
2. Relationship status: __Single __Married__ Divorced __Widowed __Separated __Other
3. Family History:

Relative	Age	General Health	Cause of death & age	Other illnesses
Mother				
Grandfather				
Grandmother				
Father				
Grandfather				
Grandmother				
Sisters				
Brothers				
Spouse				
Children				

Please list diabetes, high blood pressure, heart disease, stroke, cancer (please list type), kidney disease, thyroid, migraines, colon polyps, asthma, tuberculosis, arthritis and mental illness

Demographics

Please list any ethnicities with which you identify (e.g. White, Hispanic, etc.):_____________________

Please list your preferred language: _______________________

PAST MEDICAL HISTORY

Preventative Health Practices

A. Vaccinations:
   1. Oral Polio __yes __no __not sure
   2. Date of last tetanus shot:________________
   3. Date of last Hepatitis vaccine:____________
   4. Date of last TB Skin test: ____________ have you had a positive test:_________
   5. Date of last Pneumovax:________________
   6. Date of last flu shot: _______________

B. Women:
   1. Date of most recent mammogram:_______________ Never______________
   2. Date of most recent pap smear:__________________ Never______________
   3. Date of last bone density scan:___________________ Never______________

Your health history

Have you ever had:
__ German Measles __ Mumps __ Rhueumatic Fever
__ Diptheria __ Mononucleosis __ Polio
__ Hepatitis Type__ __ Immune Deficiency

Other illnesses or Chronic Conditions: ____
____

Allergies: list medications and the physical location, nature, and severity of your reaction: _____________
____
____

Past Hospitalizations (include surgeries, head injuries, broken bones, serious illness or injuries)
Include dates, hospital and Doctor's name.

____
____
____
____
____

Have you ever been exposed to toxic drugs or chemicals (asbestos, lead, insecticides, mercury or others)?
__ yes __ no

List your current medications; name of medication, dosage, amount and when taken during the day, include all over the counter or herbal supplements. Attach a list if necessary

____
____
____
____

Health Habits

Yes No

☐ ☐ Have you ever smoked or used tobacco products?
If yes, how much (i.e. packs/day, packs/yr)? _______ Age started: ___ Age stopped: ___

☐ ☐ Do you drink alcohol? If yes, what do you drink? ___________________
How much? ___________ per day_______ per week ________per month

☐ ☐ Have you ever had a problem with alcohol or drugs? __________if yes, please describe:
____

☐ ☐ Do you drink coffee or caffeinated teas? If so, how many 12oz cups per day?_________

☐ ☐ Do you get regular physical exercise? _________
Type of activity: _________________________ how often? _____________
For how long? __________ Time of day: ________ How long have you done this? _____

☐ ☐ Do you wear safety belt in the car? ______________

☐ ☐ Do you floss and brush your teeth regularly? _____________
When did you last you saw the dentist or had your teeth cleaned? ______________

☐ ☐ Do you have a history of periodontal (gum) disease? ________

☐ ☐ Are you comfortable at your current weight? __________
If overweight or underweight, how long have you been this way? __________
What type of weight loss strategies have you tried in the past?

__ Weight Watchers	__Jenny Craig	__Nutrisystem
__ LA Weight Loss	__ Low Carb	__Low Calorie
__ Liquid Diet	__ Exercise	__ Other

Were any successful?_______________

General Health

Yes No

☐ ☐ How would you rate your general health? __ excellent __ good __ fair __ poor

☐ ☐ Any recent unintentional change in weight? If yes, how much? __gain __loss

☐ ☐ Do you have drenching sweats or marked chills at night?

Head, Eyes, Ears, Nose and Throat

Yes No

☐ ☐ Do you have frequent headaches or a change in the type of headaches?
☐ ☐ Do you have frequent or sever pains in the neck?
☐ ☐ Do you have problems with your vision not helped by glasses?
☐ ☐ Do you ever see halos around bright lights? Last dilated eye exam: _____
☐ ☐ Are you disturbed by a roaring or ringing in the ears?
☐ ☐ Do you have trouble hearing?
☐ ☐ Is your nose usually running or congested?
☐ ☐ Do you have sinus trouble?
☐ ☐ Do you often feel a choking lump in your throat or have trouble swallowing food?
☐ ☐ Do you have frequent sore throats?

Respiratory

Yes	No	
☐	☐	Have you ever coughed up blood, not related to a nose bleed?
☐	☐	Have you ever been told that you have asthma, emphysema or another lung condition? Please list: ____
☐	☐	Do you cough more than a few times a day?
☐	☐	Have you ever had TB or been in close contact with someone who was infected?
☐	☐	Are you often short of breath?

Cardiovascular

Yes	No	
☐	☐	Have you had an irregular heartbeat or palpitations?
☐	☐	Do you need more than one pillow to be able to breathe at night?
☐	☐	Do you awaken from a sound sleep short of breath?
☐	☐	Do you have trouble with swelling of the ankles?
☐	☐	Do you have varicose veins?
☐	☐	Do your legs frequently cramp? Comments: ____

Gastrointestinal

Yes	No	
☐	☐	Do you have a poor appetite? How many meals a day? _____snacks? _____
☐	☐	Do you have a problem with bloating, belching or gas? Please circle
☐	☐	Do you have frequent heartburn or burning in your upper abdomen?
☐	☐	Do you frequently take antacids?
☐	☐	Do you have other types of abdominal pains?
☐	☐	Have you ever vomited blood?
☐	☐	Do you have trouble constipation or diarrhea?
☐	☐	Has there been a recent change in your bowel habits?
☐	☐	Do you vomit on more than rare occasions?
☐	☐	Has a health care provider ever told you that you had an ulcer? Comments: ____

Genitourinary

Yes	No	
☐	☐	Have you ever had kidney trouble?
☐	☐	Do you have difficulty holding your urine, especially when you laugh, sneeze or cough?
☐	☐	Have you ever had blood in your urine?
☐	☐	Have you ever had gravel in your urine?
☐	☐	Do you awaken at night to urinate? If so, how many times? ___________
☐	☐	Have you lost interest in sexual relations?
☐	☐	Have you had a venereal disease? If yes, which type? ______________

MEN

☐	☐	Do you have difficulty starting your urine stream?
☐	☐	Has your urine stream decreased in size?
☐	☐	Have you ever been told you have a problem with your prostate?
☐	☐	Do you examine your testicles regularly?

WOMEN

☐ ☐ Have you ever been pregnant? If yes, please indicate number of times.
__births __stillbirths __miscarriages __abortions

☐ ☐ Are your periods regular? In not describe_______________________________________
Date of last period: ________________was it normal? _____________________

☐ ☐ Do you have heavy cramps with your periods?

☐ ☐ Do you have problems with vaginal itching or discharge?

☐ ☐ Do you have frequent vaginal infections?

☐ ☐ Have you ever had a breast lump?

☐ ☐ Have you ever had discharge from your nipple?

☐ ☐ Do you do regular self-breast exams?

☐ ☐ Have you ever had an abnormal PAP? If yes, what was the date? _________________

What is your method of birth control? ____

Comments: ____

Endocrine

Yes No

☐ ☐ Have you ever had a problem with your thyroid or needed medicine for your thyroid?

☐ ☐ Have you ever had diabetes or elevated blood sugar?

☐ ☐ Have you ever been told that you have low blood sugar?

☐ ☐ Have you ever noticed a change in head, hand or foot size in adulthood?

☐ ☐ Do you have trouble tolerating hot or cold weather?

Musculoskeletal

Yes No

☐ ☐ Do you have frequent or severe back pain or foot pain?

☐ ☐ Do you have arthritis? If yes, where: ______________________________________

☐ ☐ Do you have morning stiffness that lasts more than 20 minutes?

Comments: ____

Neurologic

Yes No

☐ ☐ Have you ever had a disease of your nervous system?

☐ ☐ Do you have convulsions or fainting spells?

Comments: ____

Psycho-Social

Yes No

☐ ☐ Have you ever been admitted to the hospital for psychiatric reasons?

☐ ☐ Do you have problems with depression, unhappiness or crying spells?

☐ ☐ Have you recently considered suicide?

☐ ☐ Do you have a lot of stress or anxiety?

Comments: ____

Hematologic

Yes No

☐ ☐ Do you bruise easily?

☐ ☐ Do you have any history of anemia? If yes, when__________________________________

☐ ☐ Do you ever bleed excessively?

☐ ☐ Have you ever had a blood transfusion? If yes, when and how many? _______________

Where did you have them? ____